should only be upheld if it is morally sound and relevant in today's society. As to the alleged abandonment of the prohibition on killing, exceptions such as killing in war, killing in self-defence and capital punishment have already been made. It may be possible that assisted dying in certain circumstances may be a valid consideration, particularly if we consider the autonomy argument. We place a good deal of importance on patient autonomy in many areas of modern medical practice. I acknowledge that protection of the doctor–patient relationship, and protection of vulnerable groups are both essential considerations in this debate, which will continue to attract interest from a wide-ranging audience.

ANJALI MULLICK
Specialist Registrar in Palliative Medicine
South Thames Training Rotation

In response to Mullick

I'm not for a moment suggesting that the idea of assisted dying be dismissed without discussion or thought. I have shared my own views, arrived at after much of both! My presumption about the views of those working with the terminally ill is based on personal experience and survey evidence. In April of this year a survey of its members by the Association for Palliative Medicine (with a response rate of 68%) found that 94% were opposed to a change in the current legislation. I would call this an overwhelming majority.

Part of the ethos of palliative care is to acknowledge that dying is a natural process rather than a medical failure. Fatigue, weakness, increasing dependence and disability are an inevitable part of this process. To argue that because we have no remedy for them we could resort to the option of 'therapeutic killing' risks pandering to the very ethos that the hospice movement evolved to counter. We would do well to humbly ponder the old aphorism on the role of a physician: to cure sometimes; to relieve often; to comfort always.

I have indeed acknowledged that there are some patients who might wish to end their lives prematurely, but the question is whether their autonomy should be elevated above other concerns, for all the reasons described in my article.

As to the moral basis and relevance of the Hippocratic Oath, I don't think we have moved on as much as some would have us think. It seems to me that a prohibition on assisted dying is far more relevant to today's society than ever before. In centuries past, when very little could be done to alleviate the symptoms and distress of the dying, the argument that it was a necessary option might have carried more weight. I don't think that killing in war and in self-defence bear any comparison to what we are wrestling with here. Lastly, we abandoned capital punishment long ago, as it seemed incompatible with a humane society and because of the irrevocable consequences of getting it wrong. It seems ironic that many are now pushing for assisted dying, when the consequences of getting it wrong are equally disastrous and irrevocable.

JEFFREY STEPHENSON
St Luke's Hospice, Plymouth

Assisted dying

Responding to various recent articles in *Clinical Medicine* I agree that in many instances end-of-life care is suboptimal and everything possible should be done to achieve good palliative care for everyone who needs it. Much of the attention has focused on people with pain or physical symptoms amenable to palliation. My worry is that this leaves a group of people with conditions such as neuromuscular wasting disorders or quadriplegia who are in a predicament not amenable to adequate palliation. Such people may typically retain their mental faculties but lose the ability to bring about their own death other than by refusing sustenance – and even this option may be denied those being tube fed. Examples include instances of people with such disorders seeking assisted suicide abroad and the fictional character portrayed in the play about a quadriplegic person, *Whose life is it anyway?* Offers to 'come alongside you' or 'go through this with you' might understandably provoke anger or frustration when the help they really want is being denied them.

I am concerned that as a profession we sometimes have difficulty accepting our limitations. If someone is not adequately palliated it must be because the service is substandard or because the doctors involved lack the correct expertise, rather than recognising we may not have the answer.

I share the huge concerns widely voiced about assisted dying. However, it seems to me that for a small group of people this may be the least bad option, with as many safeguards as possible being built in. I think we need to recognise that satisfactory palliation is not possible for everyone and that some sort of assisted dying should be made available in a very limited number of instances.

DAVID GRIFFITH
Consultant Physician, Care of Older People
Mayday University Hospital, Croydon